

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-004612

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 6

STATE FILE NUMBER

**FILED JAN 25 1963**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Manchester</u>		c. CITY OR TOWN <u>Riverview</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing</u>		d. STREET ADDRESS (If outside, give location) <u>9868 Valley Drive</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>Obenhaus</u> Last <u>Obenhaus</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>2</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8-28-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Chicago, Ill.</u>
13a. FATHER'S NAME <u>William Myers</u>		13b. MOTHER'S MAIDEN NAME <u>Ella (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		17. INFORMANT Address <u>2270</u> <u>Bernice Schumacher, Lucas Hunt</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arterio-sclerosis</u> DUE TO (c) <u>General arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>Don't know</u> <u>Don't know</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>7:30</u> a.m. <u>7:30</u> p.m. Month, Day, Year		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION <u>St. Louis</u> COUNTY <u>Mo.</u> STATE <u>Mo.</u>	
21. I attended the deceased from <u>Dec. 8, 1962</u> to <u>Dec. 31, 1962</u> and last saw him alive on <u>Dec. 31st, 1962</u> Death occurred at <u>7:30 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Rafael W. Zaffy, M.D.</u> (Doctor or Nurse)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE <u>1-4-63</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
24. FUNERAL DIRECTOR <u>Drehmann-Harral, 1905 Union Blvd.</u>		25. DATE RECD. BY LOCAL REG. <u>1-2-63</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy, M.D.</u>		27. DATE SIGNED <u>1-2-63</u>	

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Ralph Laffey  
Manchester & Woods Mill Rd.  
La 7-6621  
Hrs. 2-4 Wed.

### STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Albat R. Thompson

Licensed Embalmer No. 4237

P. O. Address H. Jones

**Note:** The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.